Employment Development Department
State of California

APPLICATION FOR ELECTIVE COVERAGE OF DISABILITY INSURANCE ONLY LOCAL PUBLIC ENTITIES

Reference: California Unemployment Insurance Code Section 709

IMPORTANT

Do not complete this form unless you wish to apply for Disability Insurance only under Section 709 for ALL of your employees (excluding elected officials and appointees by the Governor). Coverage under this section of the Code does not make provision for Unemployment Insurance Benefits.

FOR DEPARTMENT USE ONLY	
EMPLOYER ACCOUNT NUMBER	STATISTICAL CODE
EFFECTIVE DATE	DATE EMPLOYER NOTIFIED
CLASSIFIED BY	DATE CLASSIFIED
SEND	NUMBER OF EMPLOYEES

PLEASE TYPE OR PRINT

1. NAME OF GOVERNMENT ENTITY — BUSINESS TELEPHONE

2. BUSINESS ADDRESS (NUMBER, STREET, CITY, COUNTY, STATE, ZIP CODE)

3. MAILING ADDRESS (NUMBER, STREET, CITY, COUNTY, STATE, ZIP CODE)

4. TYPE OF LOCAL PUBLIC ENTITY
☐ County ☐ City ☐ Other (Specify) _____

5. Law under which agency was established: (Complete a, b, c, or d)

	a. California Tax Law	TITLE OF ACT		NUMBER	DATE
	b. California Codes	TITLE OF CODE	DIVISION	PART	CHAPTER
	c. Charter	TITLE OF CHARTER			DATE
	d. Ordinance	TITLE OF ORDINANCE			DATE

6. Members of governing body of Local Public Entity, such as Board of Supervisors, City Council, District of Directors, etc.

NAME	TITLE	RESIDENCE ADDRESS	TELEPHONE	SSA NUMBER

NOTE: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions outlined in DE 1378L, Information Concerning Elective Coverage Under Section 709 of the California Unemployment Insurance Code (CUIC). Please retain your copy of DE 1378L for reference.

7. Appointive Positions: (These persons are eligible for coverage unless appointed by the Governor).

TITLE OF POSITION	NUMBER OF POSITIONS IN THIS CATEGORY	BY WHOM APPOINTED	NUMBER OF PERSONS DESIRING COVERAGE

8. Total number of employees to be covered, excluding elected officers and those appointed by the Governor _____ .

NOTE: Deductions should not be made from your employee's wages for the purpose of paying employee contributions required under the CUIC until your election is approved.

Attach a copy of the resolution in which the governing body described in Item 6 approved the filing of an application for elective coverage under Section 709 of the CUIC.

The governmental entity described in Item 1 hereby files its application under Section 709 of the CUIC to become an employer subject to the CUIC. It is understood that upon approval of the election by the Director, the governmental entity will be an employer subject to the CUIC for Disability Insurance purposes only to the same extent as other employers as of the date specified in the approval, and will remain a subject employer for at least two complete calendar years. Thereafter, this election may be terminated as provided by the CUIC.

I certify that this application has been examined by me, and to the best of my knowledge and belief, it is true and correct and made in good faith under the provisions of the California Unemployment Insurance Code.

This certificate must be signed by one or more of the persons under Item 6.

SIGNATURE	TITLE	DATE

Return completed application to:

State of California
Employment Development Department
FACD – Central Operation, MIC 94
10969 Trade Center Dr., Ste. 203
Rancho Cordova, CA 95670-6140

Questions may be directed to the above address or call (916) 464-2500